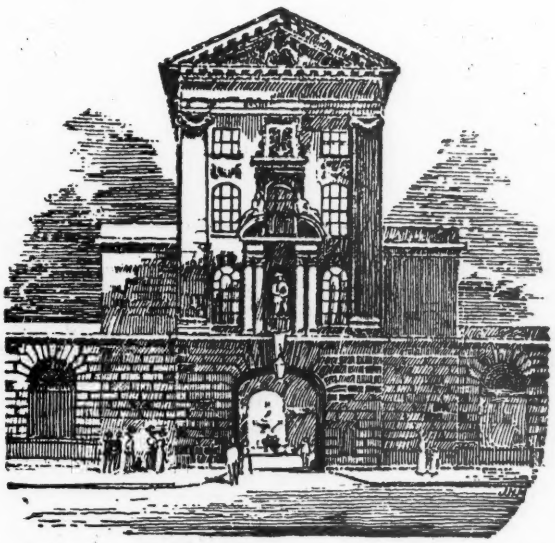
ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL. XXXIV.—NO. 12. SEPTEMBER, 1927. [PRICE NINEPENCE.

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EDITORIAL.

THE summer vacations are drawing to a close. The Bacchanal is almost finished, and there remain only the last devotees, squeezing the grape-skins in the vain hope of a final intoxication. Prohibition, willy-nilly, decrees a return to the sobriety of autumn, with an ironic injunction that we shall go 'dry.' We must forget and foreswear the delights of amorous tennis, of stern mountaineering, and of lending a hand, with an air of shamefaced nonchalance, to build a tide-defying sand castle.

But while we try to drown these recollections in the realities of hospital, the melancholy, acid tang in the morning air reminds us all the more keenly of those last days of fading glory, when the end was heralded by a serious debate on the composition of the Tuck Box, and the powers that be were diffidently told not to "bother about mending those second fifteen stockings. I—er—probably shan't want 'em."

Nowadays, instead of having queer sensations in the epigastrium and elbow-joints, three-quarters apprehensive, one quarter delightful (sensations that Mr. Lawrence ought to describe, if he hasn't yet done so), instead of wondering about this and that college or school, we make mental notes about an extra blanket, or decide to cadge some Troch. Ammon. Brom. from the Dispensary. Or we may see ourselves as the unknown and unwitting authors of apprehension in some freshman's breast, and resolve, though we may stride across the Square with the air of a houseman, to point the way, adequately, for some "little blighter" with milk scarcely dry on his lips.

Extra blankets belong really to the future days, when we "get up at night, and dress by yellow candle-light," and the October Editorial is sacred to the newcomers. This is rather the month of *Valete* than of *Salve*. The emotions of parting are, we believe, hidden in the British way under the offer of well-balanced advice. And though the approval of examining boards is sweet, it hardly confers omniscience. *Nemo mortalium omnibus horis sapit* (while we still have the Dictionary of Latin Quotations open).

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the encouragement of clinical research in organic diseases of the nervous system.

* * *

We offer the prize of one guinea for the best essay of not more than fifteen hundred words upon the subject, "Current Events in Hospital." The offer is necessarily confined, this month, to present members of the Hospital. Intending essayists should, therefore, write as for an "outside" reader. The essays will be judged in the capacity to amuse without offending, as well as to inform without being didactic. Competitors are not restricted in the events they choose to illuminate, and the term "Hospital" may be taken in its widest sense.

The Editors reserve the right to publish any of the essays submitted, and to withhold the prize if they consider no essay worthy of it.

* * *

In the columns of this number is a section headed "Annotations." It is hoped that readers who have matter of interest which hardly warrants the dignity of a fully-fledged article will avail themselves of this column. We feel that many observations, clinical and laboratory, of diagnosis, treatment and technique otherwise lost to the public might see the light in this way. The notes are unsigned, and ideally should not exceed four hundred words in length, though we impose no rigid limit.

* * *

HOUSE APPOINTMENTS FOR NOVEMBER, 1927.

Applications for these appointments will be received on or before the morning of September 17th, 1927.

The attention of prospective candidates is called to the two Regulations relating to House appointments printed below:

Candidates for the post of House Physician should have held appointments as Clinical Clerks in the wards of the Medical Professorial Unit for at least three months, except in special circumstances.

Candidates for the post of House Surgeon are required to have been Surgical Dressers to In-patients for at least six months at the Hospital, one period of three months of which should have been spent in the Wards of the Surgical Professorial Unit, except in special circumstances.

AU REVOIR.

THERE must be few among us, past or present, who can remember the Hospital without at once recalling the figure of Freddy Andrewes. He has been for so long one of the distinguished ornaments of the College that the wrench of separation is almost personal, as if each of us had lost a limb by amputation. Even to the writer his origin seems obscure and almost legendary. He was pointed at by the student with awe and admiration when he himself was but newly emerged from the chrysalis, nor in personal appearance has he much changed in those years. All the time he has moved among us and of us, in the same unaltered guise, an example of what we might aspire to be; devoted to his work, his friends and his garden; cultivating all three with the same effortless ease.

> Of him you know his merit such,
> I cannot say, you hear, too much.

Many years ago clinical medicine seemed destined to win his adherence, and though the laboratory claimed him to follow Kanthack, his clinical training has always ordered and aided his pathological bent, so that there is not, and never has been, any member of the Clinical Staff who has not eagerly sought his advice and assistance in difficult cases. Yet he has been a great deal more than a clinical pathologist, with a wider vision and a clearer sense of the obscurer fringes of knowledge than is vouchsafed to most men.

But this is not the occasion to dwell on his scientific attainments, or on his professional and professorial life among us. It is rather his personal attributes which we would recall, and for which we would render him our grateful praise now that we are obliged to see him leave us. None among us, in the writer's recollection, has moved with such complete serenity amid the changes and chances of our corner of the world—a serenity which has had nothing remote or severe about it, but has always sparkled with the delightful humour and wit which has constantly wrinkled the seldom-ruffled surface. For there were but few occasions when his calm was disturbed by anything save the quick appreciation of another's jest. His own, so frequent and so apt, were delivered with only the smallest twinkle to point the application. He has been among us the Happy Warrior,—

> Who gained a title, but who lost no friend,
> Ennobled by himself, by all approved.

In his case we know that his retirement does not mean the pursuit of idle hours. He—

> with a natural instinct to discern
> What knowledge can perform, is diligent to learn.

And his freedom from the ties of a professor's duties may, we hope, enable him to continue to add to the gaiety and sobriety of the study of medicine. *Te, jam rude donatum, summo desiderio salutamus.*

SIR BERNARD.

SIR Bernard Spilsbury is leaving the Pathological Department, where, since 1920, he has held the position of Lecturer in Morbid Anatomy and Histology. There are many, especially among the younger generations, who owe to him their first conception of morbid anatomy, whom he cajoled to a microscope by way of his epidiascope. His readiness to help and explain, and his demonstrations in the post-mortem room, made doubly entertaining by his lucid descriptions of his technique, are admired by all who know him.

Sir Bernard deserves the gratitude of those who would believe in the reality of the criminologist, for he constantly showed that the brilliance of a Sherlock Holmes was not necessarily the outcome of convenient clues supplied by a Conan Doyle. His lectures to the Abernethian Society, when he drew on his large medico-legal experience, are still vivid memories.

Those who have worked with him in the Pathological Laboratory will remember him chiefly for his courtesy: he was ever willing to offer an opinion on a difficult section, and characteristically he was not influenced or biased by the clinical history of the case. He gave his opinions as a pathologist and not as a clinician.

His industry is immense, as the organization of the new Morbid Histology Laboratory and his minutely detailed records of post-mortem material witness.

Sir Bernard is taking up his Home Office work, and hopes to complete some books for publication. His laboratory work is to be continued at University College.

He leaves behind him at St. Bartholomew's many friends, who delighted in his attainments as much as in his great personal charm, and whose best wishes follow him in his new life.

THE GRADUAL RELIEF OF CHRONIC RETENTION OF URINE.

WHEN there is an incomplete obstruction in the lower urinary tract and the cause persists for a considerable time, various changes take place both in the anatomy of the urinary passages and in the physiological processes of urinary secretion. These changes resulting from retention of urine are to a certain extent secondary to increased pressure, whereas there are others which must be regarded as an attempt to adapt the secretory apparatus to the new conditions, in other words as compensatory phenomena. This compensation is sufficient for a time to enable the kidneys to carry on in spite of the obstruction, and although progressive damage is being done to the renal tissue, yet for a while a "state of equilibrium" exists. In Cabot's *Modern Urology* it is referred to as "the peculiar balance existing between the heart, kidney, secretion of urine, and the nervous control of these in the patient who has gradually become used to over-distension of the bladder."

The knowledge of how unstable this equilibrium may be has been obtained by such bitter experience that every student is warned of the dire results which follow the clumsy handling of chronic retention. Yet, although they all learn that it is wrong to draw off the urine quickly, few of them have really clear ideas on how to draw it off in any other way. Also it is not always realized that the management of acute retention (which has been acute from the onset) is quite a different problem from that of chronic retention which has either ended in acute retention or has resulted in overflow incontinence.

Even although one is familiar with the dangers and the warnings one may be almost tricked into taking a fatal step which interferes with one of the elements in the "balanced" system and so throws the whole system into confusion. In 1923 a man of 60 was admitted to the Hospital with a strangulated inguinal hernia. It was discovered when he was under the anæsthetic that his bladder reached up to the umbilicus, though, needless to say, he had passed urine before coming to the theatre. Rectal examination revealed an enlarged prostate. With the object of preventing straining during micturition, which might prove too severe for the repaired hernia, the residual urine was drawn off there and then. The patient was unable to pass water naturally afterwards and was catheterized daily. Ten days later he died of uræmia, his blood-urea before death rising to 350–400 mgrm. per cent. To quote again from Cabot, by draining the residual urine from the bladder, "the back pressure is relieved; decompression of the kidney follows; swelling and congestion of the organ take place; and its functional capacity immediately drops to a very low point."

The explanation of the changes in the kidney, in the light of our present knowledge of the physiology of this organ, is not perfectly clear. Œdema of the lung has been recorded after too rapid withdrawal of a pleural effusion. Œdema of the brain leading to failure of the vital centres follows too sudden withdrawal of fluid under tension from within the dura mater or from the brain itself. And it seems probable that a similar

change must occur within the capsule of the kidney when the pressure is too rapidly lowered in the urinary tract.

Whatever the explanation, the change in the urinary tract which follows a sudden drop in intravesical pressure is immediate congestion with œdema and hæmorrhage. In the kidney this means suppression of urine, or at least a very severe falling off in renal efficiency, and in addition it renders the whole tract a fertile field for infection.

Some idea of the influence of drainage of the bladder upon renal efficiency may be obtained from the study of the blood-urea after the suprapubic drainage operation preliminary to prostatectomy. Again and again—so frequently as to be constant in the cases which demand the two-stage operation—one finds a rise in the urea content of the blood, which later falls and has to find a steady level before the operation is completed.

Besides the local effects in the urinary tract, a sudden fall in the arterial blood-pressure throughout the body follows the rapid withdrawal of residual urine. This is a very serious complication, for with a damaged filter the reduced filtration pressure places the excretory apparatus in a very precarious position.

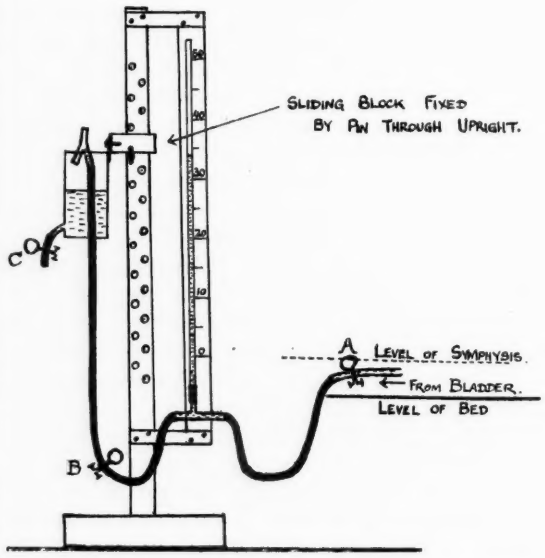
To overcome these dangers many plans have been suggested. One is to draw off the urine through a very small catheter and so insure slow emptying of the bladder. Though applicable to some cases of urethral stricture this method can seldom be used in enlargement of the prostate since the fine catheter gets hitched up in the prostatic urethra and cannot be made to enter the bladder.

Another suggestion is to pass a catheter at regular intervals, each time drawing off a greater and greater proportion of the bladder contents, till finally it is completely emptied. It is impossible to carry out this method without subjecting the patient to very severe risks. Let us suppose that half the urine is to be drawn off. This cannot be done accurately unless we know how much the bladder contains. I remember Dr. Cabot discussing this method and describing how he had drawn off all the urine and then put half of it back again. He said he supposed the man would prefer to have his own water back, rather than have some salt solution that didn't belong to him! It is unnecessary to remark that this account was a preliminary to his advocating a better method.

Repeated catheterization, however carefully carried out, brings about so many variations in the pressure the kidney has to work against that any compensatory mechanisms it may possess are strained to breaking point, and in senile cases are almost certain to fail. The case described above is a good instance of this failure. And added to all this is the risk—the certainty in fact—of infection.

The method of gradual drainage to be described is not new. It has been in use at the Mayo Clinic for the past four years, and it was while I was in the United States that my attention was drawn to it. The apparatus is simpler than others which have been described, and, though it looks crude, it is being placed on record because it can be improvised easily from materials to be found in any hospital, and it performs its functions as well as the more elaborate models.

It consists of a wooden upright upon which is a block, which can slide up and down, and which can be fixed



APPARATUS USED FOR THE GRADUAL DRAINAGE OF THE OVER-DISTENDED BLADDER.

at any height by a pin passing through one of the holes bored in the upright. The holes are bored at intervals of 2.5 cm. Fixed to the upright is a piece of wood supporting a glass tube, which acts as a manometer, being connected through a T-piece below to the bladder on one side and to an overflow tube on the other. The overflow tube is attached to a piece of glass tubing shaped like an inverted Y, which hooks on to the rim of a douche-can screwed into the sliding block. The manometer tube is graduated in centimetres, and it is convenient to have the bottom of the scale at the level of the symphysis pubis.

The apparatus is filled with water so that the fluid in the manometer tube stands at the level of the symphysis, and the overflow tube is clipped at B. A catheter is passed into the patient's bladder and clipped

to prevent escape of urine. The catheter is then connected to the apparatus and the clip A removed. The fluid in the manometer tube now rises to a height corresponding to the intravesical pressure. It is found in practice that this varies between 10 and 50 cm. of water. The sliding block is moved up and fixed so that the overflow tube is just above the level in the manometer and the clip B is removed. Urine will now continue to be secreted against the same pressure in the urinary tract as before, but it will overflow all the time into the douche-can in which it can be measured, and run off by opening the clip C.

In a few hours the height of the bladder above the pubes will be found to be getting less, and will continue to decrease as drainage goes on. In twelve hours the block can be lowered 2·5 cm., and in from three to five days, as a rule, the pressure will have come down to *nil*. The apparatus may then be disconnected and the urine collected in a bottle. If, as happened in one of our cases, blood appears in the urine, the block must be raised again at once. In the case referred to the bleeding ceased as soon as this was done, and subsequently the lowering of pressure was carried out even more gradually than before and without a recurrence of the hæmorrhage.

The apparatus has been used in five cases of enlargement of the prostate and two cases of urethral stricture. It has proved easy to handle, and the patients have expressed themselves as greatly relieved and not at all inconvenienced by it. We have not noted any rise in the blood-urea before it began to fall, and the blood-pressure has fallen gradually instead of suddenly to its "normal" level. The urinary output has been well maintained in all the cases.

Certain individuals cannot tolerate an in-dwelling catheter, and under these circumstances the apparatus can be connected just as easily to the de Pezzer tube used for suprapubic drainage of the bladder. The de Pezzer tube must, of course, be introduced into the bladder without emptying it in the process, but this may be achieved by the use of a large suprapubic trocar and cannula, the tube being passed down the cannula and only a few c.c. of urine being allowed to escape in the process. In one of our cases we made use of this method and found it presented no difficulty.

In conclusion we believe that in this simple apparatus we have the means of relieving chronic retention safely. It is not suggested that every patient who has an enlarged prostate and an ounce or two of residual urine requires its use; but in the treatment of neglected cases of chronic retention it is a life-saving device.

J. P. Ross,

From the Surgical Professorial Unit.

A CASE OF PYÆMIA DUE TO AN UNIDENTIFIED ANAËROBIC BACILLUS, ENDING IN RECOVERY.

THE following case offers points of some interest on both clinical and pathological sides.

J. J. K—, a male, æt. 20, was admitted to Dr. Langdon Brown's ward on February 20th, 1927, complaining of cough and shivering attacks for the past week.

History of the condition.—One week previous to admission, the patient had a sore throat and stiff neck. The following day he had a temperature of 104° and a rigor. He felt ill and weak. The rigor was repeated daily up to the date of admission, six days later. He developed a cough with tenacious, brown sputa, and was admitted to the hospital on the seventh day of the disease.

On admission.—The patient was flushed and sweating, alæ nasi not working. Temperature 104°, pulse 96, respirations 24. The tonsils were large "but not unhealthy apparently." The percussion note over the lower lobe of the right lung posteriorly was impaired; the breath sounds weak. No added sounds were heard. The heart was natural. Spleen and liver were impalpable; there were no petechiæ. A blood-count done on the day of admission showed 14,000 leucocytes.

Course of the disease.—During the next four days after admission the patient had two rigors. He developed friction sounds at both pulmonary bases posteriorly, and bronchial breathing on the right side in the posterior axillary line. The sputa were rusty in colour, and a report on the bacteriology at this stage noted that "the predominant organism is a large Gram-positive bacillus, almost certainly anaërobic; Pfeiffer's bacillus is absent; no T.B. seen." Two days later, however, the flora had changed, and a Gram film showed Gram-positive cocci, and Gram-negative bacilli, rather large and some in chains. On culture, staphylococci and streptococci were grown. The tonsils were now covered with a patchy exudate. This was examined for Klebs-Loeffler's bacilli and for Vincent's organisms with negative results. On the fifth day after admission a swelling was observed on the left side of the neck anterior to the anterior border of the sterno-mastoid, which did not move on swallowing. The following day the swelling had increased and was thought by some to fluctuate. A thrombosed jugular vein was suggested, and in view of this grave possibility it was decided to explore, and 2 oz. of thick, yellowish pus without odour were evacuated by Sir Holburt Waring. The condition of the jugular vein was not investigated. A Gram film

of this pus showed the presence of a pleomorphic Gram-negative bacillus in some ways resembling Pfeiffer's bacillus, but exhibiting greater variations in size and morphology, and a tendency to grow in pairs (see Fig. 1). Aërobic cultures on blood media were sterile. The patient's condition was not materially improved by the evacuation of pus. He developed pericardial friction, moist sounds in his lungs and a pleural effusion on the right side which was tapped. This contained polymorphs, and was sterile in film and culture. Dr. Garrod was good enough to inject some of it intra-peritoneally into a guinea-pig. The pig bore it with fortitude, and was none the worse, either immediately or at a later date.

Dr. Garrod obliged with further guinea-pigs; Dr. Gordon also sacrificing on our altar. The aim was to produce a suppurative orchitis, which is characteristic of *B. mallei* infections in this animal. The pigs, however, remained indifferent to this malignant fate, and apart from malaise and a localized subcutaneous abscess at the site of infection, seemed little the worse. Glanders was therefore out of court. Meanwhile it was abundantly clear that the patient was suffering from pyæmia, and it was no surprise when a few days later he developed a thoracic empyema on the left side from which some 27 oz. of foul pus were removed after resection of rib. It showed the same organism as before, in pure culture.

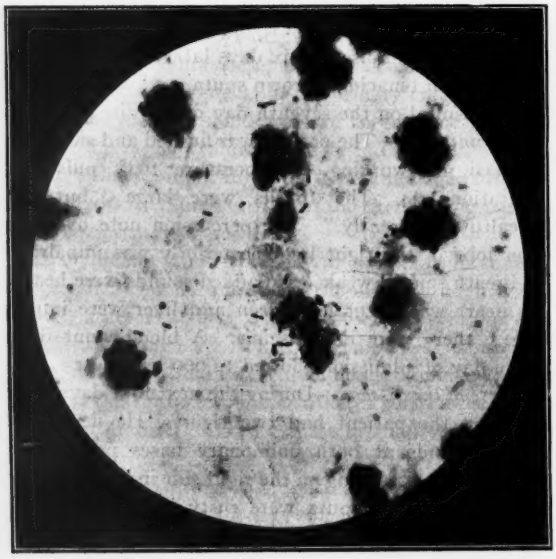


FIG. 1.—ORGANISM IN PUS FROM CERVICAL ABSCSES.

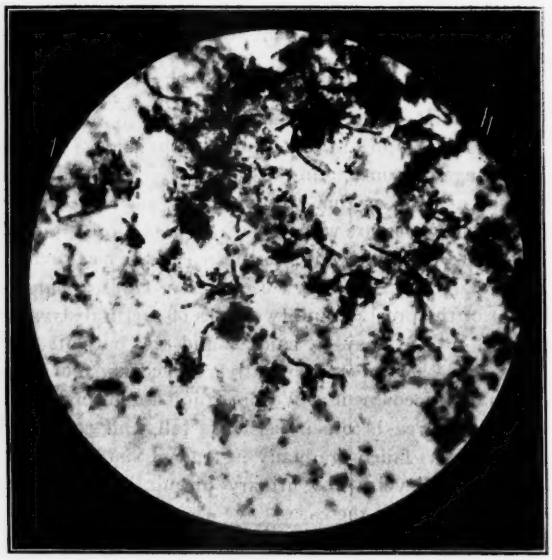


FIG. 2.—SUBCULTURE ON SOLID MEDIUM CULTIVATED ANAËROBICALLY.

Blood cultures made aërobically and anaërobically were sterile at this time, and remained so throughout the course of the disease. Fourteen days after admission the patient developed on the arms and legs small intra-cutaneous vesicles surrounded by a purpuric zone. An attempt made to withdraw some of the serum from a vesicle for bacteriological examination gave a negative result. Some days later he developed a large abscess in the right buttock. This was opened, and 12 oz. of stinking pus evacuated. There was no gas formation in the tissues. A Gram film of this showed the same organism as was seen eighteen days previously in pus from the cervical abscess, *i. e.* a pleomorphic Gram-negative bacillus. It was inevitable at this stage that Glanders—bogey for all Gram-negative bacilli—should be mooted. The alarm was raised in due course, and

This time an attempt was made to cultivate it under strict anaërobic conditions in Noguchi's medium. Turbidity with gas production appeared after 24 hours. A Gram-film showed pure growth of a small Gram-negative bacillus, some of which appeared to be coccoid and to form chains. In order to sub-culture this anaërobically on solid media, the members of the Influenza Team kindly gave me accommodation for some plates in one of their McIntosh and Fildes anaërobic jars. The conditions under which they were working necessitated that the jar should not be opened for one week. When, at the end of this time, the plates were removed, many discrete colonies surrounded by a most intense zone of hæmolysis, were present on both plates. Films from these showed a bacillus similar in many respects morphologically to that previously seen in film and culture, but

showing large involution forms as well. From this point onwards, the patient, contrary to all expectations, made uninterrupted progress, and was discharged from hospital seven weeks later completely recovered.

All efforts to subculture this organism, or to reproduce growth from the original material, failed. The colonies on the plates had evidently died out as a result of their prolonged stay in the anaërobic jar. The original pus, although kept on ice, had become sterile, possibly as a result of aërobic conditions. The discharge from the empty liver wound had become secondarily infected with staphylococci, and although the required Gram-negative bacillus was present in film on one occasion, attempts to grow it, continued over some weeks, ended in complete failure. All sources for the recovery of this organism had thus become unavailable, and further study and the hope of identification had to be abandoned.

Discussion.—Treatment consisted in repeated transfusion with whole citrated blood and the drainage of collections of pus as required. Recovery was wholly unexpected.

In view of the initial sore throat and the cervical abscess, the portal of entry was probably the tonsil. The negative blood cultures raise the interesting question as to whether the normal oxygen-capacity of the blood is not sufficient completely to inhibit the multiplication of strict anaërobes within the blood-stream. This patient had pyæmia, but not septicæmia.

From the bacteriological point of view, the following points emerge. The bacillus was Gram-negative and strictly anaërobic; attempts to grow it aërobically were consistently negative. In Noguchi's medium it produced turbidity and gas formation. On solid media it formed whitish, limpet-like colonies, 2–5 millimetres across, intensely hæmolytic. In fresh material it varied greatly in size, ranging from that of Pfeiffer's bacillus to the dimensions of a plump coliform organism. There was a definite tendency to grow in pairs in fresh material (see Fig. 1), and in parallel formation or in tangled masses in Noguchi's medium. "Beading" and polar-staining were marked with Gram's stain both in the pus and in culture, recalling *B. diphtheriæ*. Polar bodies, however, were absent when acetic acid toluidine blue was used. In fluid media the "beading" was so marked as to resemble a coccus growing in chains. The faintly staining outline of the bacillary envelope could, however, usually be seen between the interrupted "beads." What appeared to be spores were constantly present, central or sub-terminal. On solid media (see Fig. 2) large, swollen, involution forms occurred. The classification of this organism presents difficulties. As far as I am aware, all the pathogenic obligatory anaërobes are Gram-positive, with the possible exception of *B. chauvæi* (the baciilus of "quarter-evil"), which is said by some workers to be Gram-negative. This, however, is highly pathogenic to laboratory animals. It is known that many spore-bearing anaërobes, *e. g. B. sporogenes*, or *Vibrion septique*, become Gram-negative in old cultures, but this fact is not really relevant to the organism under discussion, since it was Gram-negative in all phases of its life-cycle; in fresh material as well as in young cultures. An examination of the text-books of Muir and Ritchie, Stitt, and Hiss-Zinsser, and a somewhat hasty search through the almost overpowering erudition of Kolle and Wassermann's *Handbuch*, have failed of illumination on this point.

I am indebted to Dr. Langdon Brown and Mr. H. L. Wilson for their permission to publish this case. I have also to thank Dr. Gordon, Dr. Canti, and Dr. Garrod for advice and assistance with the bacteriology; and Dr. Wilfred Shaw for his kindness in making the two excellent micro-photographs.

J. CONWAY DAVIES.

A CASE OF OSTEOMYELITIS OF THE ISCHIO-PUBIC RAMUS WITH OBSCURE SYMPTOMS.

I HAVE ventured to publish the notes of this case which presented some unusual features. Not only was the situation of the lesion uncommon, but the subsequent abscess-formation with its spontaneous drainage and the eventual recovery merits, I think, special record.

F. T—, æt. 10, was admitted to Surgery Ward under the care of Sir Thomas Horder on May 15th this year, complaining of pain in the left groin.

The history of the case is as follows: For two days he had complained of malaise, vomiting, sweating, pain in the back and left groin, associated with a sore throat.

On admission his temperature was found to be 105·8° F., his pulse frequency 140, and his respirations 26.

When examined his throat was found to be red and swollen; his abdomen was not rigid, and no tumour was palpated, while his pain was referred to the left groin. The right testicle was absent from the scrotum. No tenderness was complained of on rectal examination.

The movements of both hip-joints were full and equal, while on the right leg, just below the knee was a small septic spot discharging purulent material. Nothing abnormal was discovered in the urine.

The patient was subsequently transferred to Rahere Ward, where he remained till May 30th, during which period the pain gradually became less, while remaining febrile, the temperature varying between 98° F. in the morning and 102° F. in the evening. During the last two days of the patient's stay in Rahere, he commenced to complain of hypogastric pain and a tendon swelling developed in the right ischio-rectal fossa.

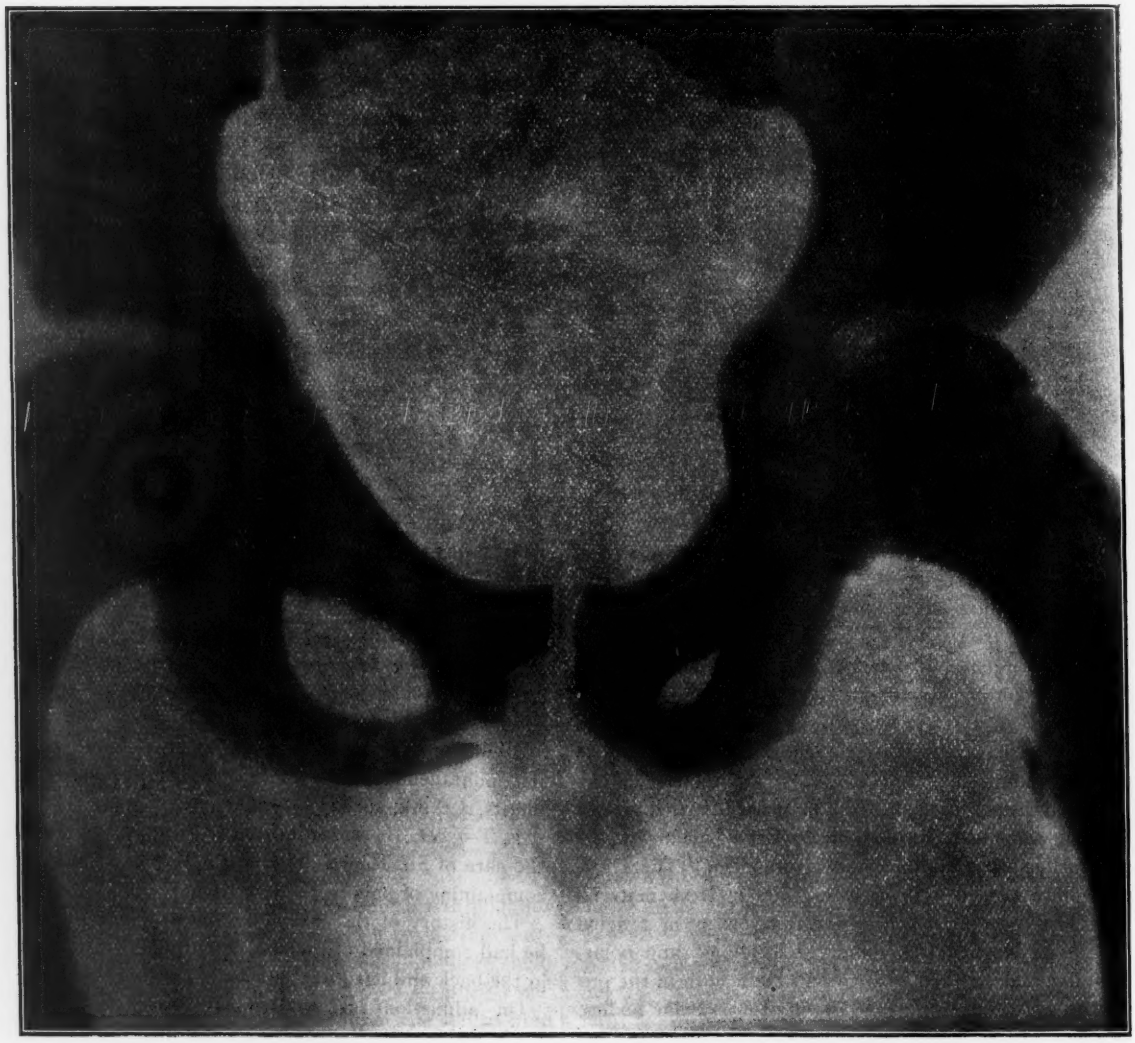
While in the Medical Ward an agglutination test was performed which was negative to typhoid and paratyphoid A and B.

On May 30th the patient was seen by Mr. Rawling, and a diagnosis of ischio-rectal abscess made. The abscess was incised and drained, and the patient transferred to Coborn Ward.

The pathologists reported that the pus from the abscess contained streptococci having the cultural characteristics of *Streptococcus pyogenes*.

When seen following the operation, there was still some hypogastric pain and rigidity, together with a spasmodic flexion of the right leg at the hip joint, extension and abduction of the hip being resisted, and causing pain. Actual rotation of the head of the femur in the acetabulum was full and free from pain.

Pain now began to be complained of during micturition, while the hypogastric pain and spasmodic flexion



SKIAGRAM OF PELVIS, SHOWING RAREFACTION OF SYMPHYSIS AND LEFT PUBIC RAMUS.

of the hip increased. The application of hot fomentations to the hypogastrium brought no relief, and the symptoms persisted till June 3rd, when the specimen of urine passed in the morning was observed to contain about ℥ij of thick, creamy pus. Following the discharge of pus in the urine, the hypogastric pain and rigidity temporarily disappeared, while the spasmodic flexion of the hip decreased, only to return a few days later.

The pathological report on the urine showed the presence of pus, together with Gram-positive cocci in long chains. No tubercle bacilli were seen.

A blood-count carried out on June 8th was as follows: Red blood-cells 4,300,000 per c.mm.; white blood-cells, 17,000 per c.mm. The daily specimens of urine contained steadily reduced quantities of pus.

For the course of the next few weeks the severity of the symptoms varied from day to day, the patient remaining febrile during the whole period.

On June 30th cystoscopy was performed by Mr. Roche, the patient being under a general anæsthetic. The mucous membrane of the bladder was seen to be congested, but otherwise normal, no discharging sinus into the bladder being observed.

While under the anæsthetic an abdominal examination was made. Neither kidney was palpable, but there was a slight resistance felt in the left iliac fossa, while movements of the left hip-joint were not so free as those of the right.

Two days later an X-ray picture was taken of the pelvis, the report being as follows:

"The hip-joints appear normal. There is disease of the left ischio-pubic ramus and also probably of the pubic symphysis. There is considerable mottling of the bone of the ramus, and there are no sharp outlines to the bones forming the symphysis.

Diagnosis: ? Osteomyelitis; ? tuberculous disease.

On July 7th a red, tender, painful fluctuating swelling the size of a pigeon's egg appeared in the perineum in the midline, just posterior to the scrotum. This was incised and a quantity of pus evacuated.

The pathological findings on the pus were that it contained Gram-positive cocci in long chains, having the cultural characteristics of *Streptococcus pyogenes*. No staphylococci or tubercle bacilli were seen.

Following the incision of the abscess the symptoms rapidly and entirely disappeared and the temperature subsided, while the urine remained free from pus.

A further X-ray picture was taken which showed no change since the previous picture.

The patient was discharged to a convalescent home on July 30th.

During the latter part of his stay in hospital his general condition greatly improved, while he put on weight, being under-nourished and puny for his age on admission.

I am indebted to Sir Thomas Horder, Mr. L. Bathe Rawling and Mr. J. E. H. Roberts for permission to make use of these notes.

C. B. V. TAIT.

YUNGCHUN.

WE have been sent the following graphic picture of medical missionary work in China by the Presbyterian Church Officer, Russell Square.

At present and ever since the Kuomintang came into governing power here we have had peace; there has been no fighting, no brigandage in the city, no unjust taxation, or at least very little of it; and of course this is entirely different from what we have been accustomed to. We had always fighting around here; we always were having people carried off by brigands; the people for years had been ground down by illegal taxation. With this comparative peace one would think that the district would begin to look up, but that is not the case as there doesn't seem to be enough money to make things brighten up. People are flocking abroad to earn this money, and will come back as soon as they can to make a fresh start here. The district is still becoming rapidly depopulated, the streets have a very deserted appearance and business is practically *nil*. All these changes have modified the extent and nature of our hospital work here. During the past few years my big work here has been that of an emergency surgeon, a sort of war-time surgeon. There were so many seriously wounded people—average 100 yearly—and we were called upon to deal to the best of our ability with all kinds of grave gunshot wounds. We have recovered bullets from almost every part of the human anatomy, and tied all the more important arteries that one can get at in a surgical way for primary bleeding and secondary hæmorrhage. We have been tackling all those horrid chronic cases of neglected or badly treated wounds, *e. g.* infected joints with sinuses all over the place, badly united fractures with sinus complications, traumatic aneurysms with occasional weepings of blood from infected sinus tracks, etc., etc. These were a perfect nightmare to us, as they all required formidable operations to deal with them satisfactorily, and they all bled like blazes. Now this kind of work is changing,

and we have only the occasional very chronic gunshot wound case to deal with, *i. e.* the residue of last year's wounded are coming to us still. This year our type of operative work is thus lighter, and our unusually big out-patient work is smaller because of the rapid dwindling of population I think. It might interest you if I gave you a few of the types of in-patients we have in residence at this time.

1. *Double glaucoma.*—Young man, medical treatment, no better, may require operative interference.

2. *Traumatic cataract with dislocated lens.*—Eye completely blind, great pain and headache. Lens removed with difficulty. Patient completely relieved.

3. *Juvenile cataract.*—Requires discission (needling) to be done to-morrow.

4. *Gonorrhœal ophthalmitis.*—One eye completely gone, one eye faint perception of light. Vaccine treatment. Requires iridectomy later on.

5. *Gunshot wound. Sinus in back.*—Sinus leads down between two of lower ribs to front of back-bone. Curettage. Getting better.

6. *Gunshot wound, wrist.*—Infected sinuses all over the place; requires amputation; patient refuses.

7. *Lacerated wound, huge, back of leg, over heel tendon.*—Injury due to falling of beam. Wound cleaned and trimmed. Healing.

8. *Carbuncle, huge, 8 in. by 6 in.*—On neck and shoulders and head. Excision; desperate condition due to erysipelas. Now better daily.

9. *Chronic osteomyelitis, tibia.*—Removal lower portion of bone. Improving daily.

10. *Advanced leprosy.*—Hydrocarpate of iod. injections. Slightly better.

11. *Gonorrhœal urethritis.*—Vaccine treatment. Better.

12. *Adult phimosis totally adherent.*—Patient unable to urinate properly. Modified circumcision successful.

13. *Chronic leg ulcer. Large spleen.*—Tonic medicines, dressings. Improved.

14. *Syphilitic ulceration, arm.*—606 injections. Ordinary specific treatment. Better.

15. *Traumatic stricture of urethra. Urine passed by sinuses in perinæum.*—3 months' history. Fall from tree. Patient in pitiful condition. Urethral instrumentation. Passage found. Rapid dilatation, entirely successful. No leak now. Large stream.

16. *Hæmorrhoids internal and fistula.*—Excision. Doing well.

17. *Menopause.*—She thinks lungs and heart in putrefactive state. Tonics. Better.

18. *Brothel inmate.*—Syphilis acute. Specific treatment. Better a little.

19. *Complete atresia vagina.*—Injury at childbirth 1 year ago. Adhesions removed. Vagina reconstituted.

20. *Congenital syphilis.*—Prominent sabre-bladed tibiæ, ulcers. Mercury iodides, etc. Better.

These are most of the types I have in residence just now. Not a very brave show. Of some of the types we have quite a number of patients in hospital at present. The chronic ulcer type, the syphilitic type, the leprosy type, gunshot wound type, are all quite generously represented in our present residents. Out-patient work deals much with malarial and other parasitic infections. Venereal diseases, leprosy and eye troubles. We sometimes get through an ounce of quinine daily.

INDUCTION OF PREMATURE LABOUR BY MEANS OF A STOMACH-TUBE.

RECENTLY I was present at a meeting of the Cambridge Medical Society when Dr. Campbell Canney described "A new method of induction of premature labour." I have since been able to give this method a trial.

I have a patient whom I have attended in two previous confinements. At both of these confinements I have had to obtain the assistance of one of my colleagues on account of the smallness of the patient's pelvis. It is a pelvis of the small round type, and it is a remarkably rare deformity in the Fens, in fact it is the only case I have seen out of 140 women I have attended in this district. Both previous labours were protracted, and eventually forceps had to be applied, and in each case the head had not become fully engaged. Labour was therefore terminated with difficulty.

The patient again became pregnant during the latter part of December, 1926. She naturally had a great dread of another confinement. After consultation with my colleague, I decided to induce about the thirty-second week.

The patient was shaved and the external genitalia were painted with picric acid. A vaginal douche was given. A very large Ferguson's speculum was then introduced, and the cervix was swabbed with picric acid. Sterile towels were packed round the mouth of the Ferguson's speculum. A No. 16 stomach-tube was then passed into the cervical canal, and gradually introduced into the cavity of the uterus by means of a pair of sponge forceps. The Ferguson's speculum remained in position all this time, and made an excellent sterile canal for the tube to lie in, the vaginal walls being quite cut off. About 1 in. of the tube was left protruding from the cervix. The whole operation was performed without

an anæsthetic, and I was impressed by the ease with which the tube was introduced, and the very small amount of discomfort caused to the patient.

The operation was performed at 3 p.m. on July 29th. The patient remained quite comfortable until the evening of July 31st. She then had a few small pains and the tube was expelled. The pains soon passed off. At 11 a.m. on August 1st the membranes ruptured, but no pains were present. The cervix would admit two fingers. The head had not then entered the brim of the pelvis. At 11 p.m. weak pains came on every 8–12 minutes, and these continued until 3 a.m. They then passed off. At 2.30 p.m., August 2nd, the pains returned, and were more severe, more frequent, and more regular. The cervix began to dilate, and the head began to descend. I found that the presentation was R.O.P. At 6 p.m. the cervix was fully dilated and the head was well down. At 9 p.m. there had been no further appreciable progress, although the pains had continued regularly. The presentation was still R.O.P. The patient began to show signs of exhaustion. She was anæsthetized, and labour was terminated by means of forceps. A male child weighing 3 lb. was delivered. There was very little hæmorrhage, and the placenta came away very easily. The membranes, near the edge, where rupture had occurred, were congested, presumably from the presence of the tube. On the evening of the third day of the puerperium, and during the fourth day, the patient suffered from trigeminal neuralgia, and the temperature rose. Apart from this, the puerperium has been a normal one. The child is beginning to gain weight, and is taking 1½ oz. at each feed.

I am under the impression that Dr. Canney told us that labour may commence as early as eighteen hours after the insertion of the tube. In the case of a primipara he usually gives an anæsthetic. In my case the woman did not resent the operation in the least, nor did she experience any discomfort from the presence of so large an amount of rubber tubing.

A. W. MARRISON.

ANNOTATIONS.

Contributions to this Column are invited.

A CASE OF URÆMIA.

THE following case is recorded in order to illustrate the importance of an easily performed, but frequently neglected, investigation of the urine.

F. M—, æt. 30, male, was admitted to Sandhurst Ward on February 19th, 1925, complaining of incessant vomiting. The history was that for six months patient had had attacks of slight epigastric pain coming on one hour after meals and partially relieved by vomiting the food just taken. He had also recently been constipated.

For the last three weeks he had been vomiting continuously, the vomited material consisting of bile streaked with blood. There were no urinary symptoms. Past history: Malaria in 1915.

Family history: Father died, æt. 33, after severe vomiting (cause not known). One brother died, æt. 31, with similar symptoms; on post-mortem examination "chronic nephritis" was discovered. On examination the patient was found to be thin, sallow in complexion, and intensely anxious on account of his family history. The tongue was rather dry.

Vomiting occurred almost as soon as food was taken and was effortless and projectile in character.

The lungs were normal and the heart was not enlarged. Blood-pressure 110 mm. Hg. systolic, 60 mm. diastolic.

Abdominal examination was entirely negative. Central nervous system normal; optic fundi normal. The urine was very pale, acid, specific gravity 1010. It contained a very faint trace of albumen. The centrifugalized deposit showed a few red cells and rather more white cells, but no casts.

Blood-urea: 0·70 grm. % (normal 0·02–0·04 grm. %).

Thus the case was proved to be one of uræmia, in spite of the absence of cardio-vascular changes and the relatively normal appearance of the urine. This diagnosis was confirmed at autopsy six days later when typical small white kidneys were found.

In a patient who has been vomiting for several days as a result of toxæmia or of organic obstruction in the gastro-intestinal tract, the body-fluids tend to become concentrated as a result of the dehydration which occurs. In such cases the urine is also highly coloured and concentrated, and the specific gravity is found to be high. Conversely, prolonged and obstinate vomiting associated with a constantly fixed *low* specific gravity of the urine is almost certainly due to uræmia, and such findings should always suggest the necessity for a blood urea.

It must be remembered, however, that true obstructive vomiting, *e. g.* due to pyloric obstruction, may also cause some degree of dehydration and concentration of the body-fluids, with a consequent rise in the blood urea. In such cases the blood urea rarely, if ever, rises above 0·20 grm. %, and the specific gravity of the urine is found to be *high*. A constant inability to excrete urine of higher specific gravity than 1012, in spite of the presence of some abnormal factor tending to cause concentration of the urine, is always a sign of serious renal inefficiency.

A CASE OF COMA.

F. C—, æt. 45, a decorator, was admitted in coma. A year ago he had suffered from cellulitis of his right arm, which rapidly healed after incision. Six months ago he had several "swellings" on the back of his neck. These were presumably boils.

Apart from these two events he had been in his usually good health, which was marred only by a slight morning cough with a little sputum containing occasionally a few streaks of blood.

One month ago he began to suffer from "catarrh." His cough was worse and he brought up more sticky phlegm. This was treated by his doctor with much improvement.

One week ago he became suddenly deaf in his right ear. Four days ago he had his ears syringed, after which he suffered from "terrible" ear-ache. During that night his pain ceased and a little discharge appeared. He then felt very much better. On the day before admission he had a bad headache, and was very restless during the night.

On the day of admission he vomited several times and had diarrhœa. His bowels had usually been constipated. There was no disturbance of micturition.

In childhood he suffered from rheumatic and scarlet fever.

He was admitted at 8.30 p.m. in delirium, and striving to get off the stretcher. The pupils were small, equal, and reacted to light. Eyeball tension was normal. The tongue was dry and brown and there was no smell on the breath. Lips were cyanosed and parched. No discharge could be seen in either ear. There was doubtful neck rigidity.

Temperature was 104°. The pulse was 104 per minute and regular. Blood-pressure was 175 systolic, 110 diastolic. The apex-beat could not be felt. Otherwise nothing abnormal was discovered in connection with the heart. Respirations were 35 per minute, and the

lungs revealed no abnormal physical signs. The respiration was of the abdominal type.

The bladder was distended, and otherwise nothing abnormal was discovered in connection with the abdomen.

Knee-jerks could not be obtained and there was a doubtful Kernig's sign.

A catheter was passed. The urine was acid, the specific gravity 1026; sugar and ketone bodies were present in large amount. A little albumen was precipitated. The blood-sugar was found to be ·25%.

At 10.30 p.m. he was given 50 grm. of glucose by mouth and was given 50 units of insulin. Eyeball tension was still not subnormal, but the left pupil was noticed to be a little larger than the right and reacted more sluggishly.

At 11 p.m. he was deeply comatose and cyanosed. There was a convulsion in which his whole body became rigid and the head retracted. The jaws were firmly clenched. Spasm lasted two or three minutes, and was followed by general relaxation and grinding movements of the jaw. Breathing was very irregular during the attack and there was apnœa for about one minute. When it had passed off there was a large subconjunctive hæmorrhage.

At 11.30 lumbar puncture was performed. 40 c.c. of cerebro-spinal fluid was withdrawn under increased pressure. It was turbid, and a greyish-white sediment settled. A clot formed rapidly. Polymorphonuclear leucocytes were present in large number. Organisms having the morphology of pneumococci were seen.

At 12 midnight a catheter was again passed. There were still large quantities of sugar and 20 more units of insulin were given. Coma was deeper and the temperature had risen to 105°.

At 4 a.m. watery, blood-stained fluid began to exude from nose and mouth. Periods of apnœa about one minute in duration occurred. Cyanosis increased. Sugar was still present in the urine in lesser amount.

At 8 a.m. he was still passing sugar; fluid from mouth and nose increased, and he died at 8.30 a.m.

At the post-mortem the vertex and base of the brain were covered with purulent exudate, which extended downward through the foramen magnum. Pus containing pneumococci was demonstrated in both middle ears. Permission for further examination of the body was refused.

The discovery of glycosuria with ketosis suggested at first that this was a case of diabetic coma, precipitated by an acute infection. The raised blood-sugar also favoured this view, although a higher figure might have been expected.

It was not, however, until lumbar puncture had been performed that the real nature of the condition became evident. Meningitis is said to produce hyperglycæmia and glycosuria, and the ketosis present may have been due to inability to take any food during the few days preceding admission to hospital. Of significance is the fact that the eyeball tension throughout was not lowered.

AN UNUSUAL METHOD OF TREATMENT OF MORPHIA POISONING.

THE danger in all cases of morphia poisoning lies in the failure of the respiratory centre, and after appropriate treatment has been employed to eliminate the poison, every effort should be made to stimulate the centre. We are told to give strychnine and atropine hypodermically, not strong coffee by the mouth or rectum; and to walk the patient about so that the muscles may increase the amount of CO_2 in the blood; but the easiest method of stimulating the centre when the facilities are present is to make the patient breathe a mixture containing 10% of carbon dioxide.

A woman, æt. 21, who had been subject to such severe attacks of asthma that she had been admitted to the general wards on three occasions during the last nine months, had an unusually severe attack. As she had failed to respond to the routine treatment, including adequate doses of adrenalin, she was given morphia, gr. $\frac{1}{4}$, atropine gr. $\frac{1}{100}$, hypodermically at 10 a.m., and as there was no improvement this was repeated at 3.30 p.m. By 6 p.m. she presented the typical clinical picture of acute opium poisoning as she lay with an ashen complexion and pin-point pupils—having slow, shallow respirations and an only just palpable radial pulse. The more usual methods of treatment having been tried without any improvement in her condition, it was decided to attempt to stimulate her respiratory centre with carbon dioxide given by means of a Boyle's anæsthetic apparatus. An intranasal catheter was passed, and oxygen containing for the first half minute 5% and subsequently 10% of carbon dioxide was administered. There was immediately a dramatic change in the patient's condition, for within thirty seconds her respirations became deeper and her cyanosis disappeared. She had recovered sufficiently to speak 1½ hours later, but the catheter was not removed until four hours later, when the patient had nearly completely recovered. In our opinion this case would have proved fatal treated by any other method.

CORRESPONDENCE.

AS SHE IS WROTE.

To the Editor, 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—I enclose for publication in your JOURNAL a few of the gems collected since I have been a practitioner in the Fens.

Yours sincerely,

A. W. MARRISON.

Ivy House,
Manea,
Cambs.;
August 12th, 1927.

DEAR SIR Will you anted me in incunfindmed at the end of august Pleause wood mind Hask the nirst for me if not to much Trubel your trl Mrs. A. B—.

To
Dr
Will you come and see me Mrs —— as I have got pain in the left side and round the Kinder

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READERS' OPINIONS.

To the Editor, 'St. Bartholomew's Hospital Journal.'

DEAR MR. EDITOR,—In my opinion the funny articles at the end of the JOURNAL are the only ones worth reading.

I think those written by "M" are jolly good.

Yours truly,

OUTSPOKEN.

To the Editor, 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—I am a very old reader of the JOURNAL, and have followed its career these many years with much appreciation. I hope, therefore, you will pardon me if I encroach for a few lines on your space to agree with and reiterate the sentiments expressed by W. K. P— last month.

He deplores, in no uncertain terms, the introduction of a spirit of irreligious and cynical levity to the fundamental facts of science. Unfortunately this scoffing tendency is not confined to the sphere of physic, but seems to have spread through every walk of life.

In my day, if a man wished to say something funny, he said a definitely funny thing (no doubt remained in the minds of his readers that he at least intended to be amusing). If he desired to make a serious statement, he did so in a few well-chosen words.

But times are changed. The modern conception of humour appears to consist in ridiculing, not in a bluff and open fashion, but in a sly (termed subtle), sneering manner the very facts which are the foundations of life and science.

You may consider me just an old-fashioned, conservative dodderer, harping on the evils of modern thought, but I do feel that this attitude of contempt, clothed as it is in a pseudo-intellectual terminological garb, is a very real danger when applied to the bed-rock principles of science.

By all means let us be capable of laughing while we work, but let us beware of jeering at the few facts we feel are true. The habit may become convincing, and then, having destroyed the facts, a void alone remains.

I am a plain man, and can only envy the power of expression of your correspondent, who so ably pours the cold douche of criticism on the exotic flower of obscurantism.

I wish to take this opportunity of saying how much I enjoy the JOURNAL. I anticipate its monthly arrival with keen pleasure, as forming the link between those past associations which I most treasure and my present rather lonely life.

Yours faithfully,

A SUBSCRIBER.

To the Editor, 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—Some articles of mine you have been good enough to publish appear to be the chief manifestations of the creeping spirit of cynical levity deplored by your correspondent of last month. From my contributions I stand accused as a cynic! Light-minded! A positive menace!

Far from resenting W. K. P—'s invective, I am gratified to learn that I am such a devil of a fellow. (By what strange process does he conclude that the feelings of such a monster are worthy of consideration? Perhaps he hopes that fundamentally I am all that a mother could wish.) Having suffered for years under the delusion that I was shy and retiring, I find that I have a Positive Personality, bolstered by the vices of precocity and irreligion!

Anxious to understand my true self still further, I should like to know where my menacing qualities are displayed, and particularly those pieces which passed W. K. P—'s understanding.

I am grateful for the masterly demonstration of the dangers of verbosity.

My sincere interest in the ultimate welfare of science is my only excuse for suggesting to W. K. P— that to take a spiritual resemblance to certain Cambridge undergraduate journals on hearsay is dardly a good example to those struggling in the obscurities of pseudo-science. Surely we are taught to verify our references?

I must apologise for the tone of this letter, but W. K. P—, after his implications of both narrow-mindedness and low-mindedness, can hardly grudge a cynic a vulgar snarl or two.

I am,

Yours sincerely,

"M."

STUDENTS' UNION.

THE ABERNETHIAN SOCIETY.

WE apologize for the error overlooked in our publication of the Abernethian Society report of last month. Page 188, col. 1, line 45 should, of course, read: ". . . Sodoma; that of St. Jerome, by Murillo; and Luca Signorelli's . . ."

[ED., *St. B. H. J.*]

CRICKET CLUB.

THE result of the cricket match *versus* Guy's Hospital, for the Inter-Hospital Challenge Cup, was a win for Guy's by six wickets. The full description of the match is unavoidably held over until next month.

REVIEWS.

AN INTRODUCTION TO THE LAW AND TRADITION OF MEDICAL PRACTICE. By WILLIAM SANDERSON, M.A., LL.B., and E. B. A. RAYNER, B.A., LL.B. (London: H. K. Lewis, 1927.) Pp. xiv + 76. Price 7*s.* 6*d.* net.

Every medical student will read this book with interest and appreciation. It will appeal to him because it obviously deals with matters that are of practical importance to him, and it has the additional advantage that it deals with a subject which is in most medical schools taught very inadequately. It is well written and can be recommended unreservedly.

Some of the comments about medical practice make excellent reading. Referring to the conflict of interest between practitioners and their patients, the authors say:

"The former can only get a living where trouble exists, and the latter desire to have trouble completely eradicated. Prevention is a much more valuable service than cure, and it is somewhat anomalous that it is much worse paid. To get medical and legal services properly performed, society has therefore depended on the noble traditions and high standard of honour of the learned professions."

On the other hand there are certain criticisms which must be put forward. The authors state in the preface that they have not touched upon public health or forensic medicine, and these omissions seriously decrease the value of the book. Every practitioner now has legal responsibilities which play an important part in his everyday life, and which should not be ignored in a book with the above title.

For some mysterious reason the authors have included the Central Midwives Board as a body concerned in the education and discipline of the medical profession, and elsewhere they suggest that it is contrary to etiquette to inform a patient when there is disagreement between a practitioner and the consultant.

It is unfortunate that either by the action of the General Medical Council or from their publications, or for some other reason, the writers appear to be of the opinion that while the profession generally is prohibited from advertisement, yet—"The General Medical Council makes exceptions in cases of eminent members of the profession who have been permitted to write in the newspapers, while less eminent members of the profession have been struck off the register for doing exactly the same thing."

No wonder the comment is that "It is difficult to say on what principles the exceptions are based," but possibly if the writers go more deeply into the subject they will find that the statement that they have made needs some qualification.

Another error which needs comment is the fact that four medical bodies are given in a list as being defence associations. Only two of this list actually carry out such a function.

The great and continuous amount of work undertaken by the Medical Defence Union and other defence societies proves the need for more careful attention to this subject in the ordinary medical curriculum. No part of the medical student's training is likely to be of greater practical use to the practitioner than the instruction he recieves in the legal responsibilities of practice, and the relationships that exist between the doctor and the state and the law, and the appearance of this book is welcome as a useful addition to the literature on the subject.

A SYNOPSIS OF HYGIENE. By W. W. JAMESON, M.D., and F. T. MARCHANT, M.R.San.Inst. Second edition. (London: J. & A. Churchill, 1927.) Pp. 514. Price 18*s.* net.

The first edition of this book appeared about seven years ago, and it has established a recognized position of usefulness for students in Public Health. The present edition has resulted from a need for the introduction of recent developments and legislation, as well as from the fact that the scope of the D.P.H. examination has been considerably extended.

In its present condition, however, the book has a limited appeal. Although it may claim to be a summary or synopsis of hygiene and related subjects, yet it is not likely to attract any reader except the student preparing for the D.P.H. examination, and even he must inevitably treat it more as a book of reference than as a volume for systematic reading. It will find a useful place, however, on the bookshelf of such students.

The book gives one the impression that too much has been attempted. The preface rightly states that "in a work of this nature chemistry can be dealt with only in a superficial manner," and it is doubtful whether there is any real need for a book which attempts to cover such a wide area as hygiene, public health, public health law, chemistry, physics, vital statistics, etc. Post-graduate students for public health who are working for the D.P.H. should be assumed to possess already a reasonable scientific training. If they have not this foundation, they can easily acquire it elsewhere.

The inter-leaving of certain sections of the book is of very doubtful advantage, and adds seriously to the bulk of the volume.

Most of the subject is dealt with in a short and concise and easily understood manner. In some parts a rearrangement of the matter would materially help the memory of the student, while a careful revision should eliminate such an antiquated and unsatisfactory method of describing a W.C. cistern as a "siphonic water waste-preventer."

Under the heading "Sewage Treatment" most of the processes are admirably described, but it is doubtful whether the average student will obtain any clear or coherent idea of how the various processes can be interchanged in practice, and also what effect exactly each process has upon the composition of the sewage.

Ventilation is dealt with discreetly, and too much emphasis is not laid on the new theories which tend to belittle the older-fashioned ideas about the necessity for fresh air. In the directions given about the examination of the ventilation of a room, it is wisely suggested that the amount of CO_2 present should be estimated. Heating and lighting, however, are given a somewhat disproportionately small amount of space in the book.

In connection with foods, the adulteration of milk and the subject of milk frauds are dealt with inadequately, and this meagre allowance might be compared with the excessively detailed information given about canned foods.

Other important parts of the work of the M.O.H., such as the administration of the Midwives Acts, appear to receive small attention, the whole of this subject being dealt with in little more than a single page, or about the same space as is given to the description of the Midwives and Maternity Homes Act of 1926, which is presumably favoured with special attention merely because it is recent.

In their determination to be up to date, the authors treat recent material with special favour, and they have actually anticipated the passing of the Mental Deficiency Bill, 1926, thereby necessitating the insertion of an erratum, as that Bill failed to become law. The Milk and Dairies Order, 1926, is quoted in full, occupying a lot of valuable space without much benefit to the student, who would gratefully appreciate a useful summary.

In connection with infectious diseases, the belittlement of systematic swabbing and supervision of known diphtheria carriers constitutes dangerous teaching for public health students, as recent events are calling into serious question the prevailing practice in the London area of ignoring the valuable information which can be obtained by bacteriological investigations connected with an outbreak. The subject of the prevention of venereal disease is, unfortunately, dealt with in such a way as is likely to give the student a prejudiced view of the actual facts. Surely the student should be told that, although the reasons stated led to the repeal of the Contagious Diseases Acts, yet careful investigators and observers have asserted that in those areas where those Acts were actually in force, venereal diseases decreased, and that venereal diseases increased again in those areas after the repeal of the Acts, although in the Army generally the incidence of venereal disease had decreased. This is a controversial subject, concerning which the student should be given the statements on both sides. Similarly, with regard to the use of preventives as a method of dealing with this evil, the case for the vigorous adoption of such methods is presented in an altogether inadequate fashion, whereas the arguments against are set out in full. The unsatisfactory way in which this subject is dealt with might be compared with the very thorough and extensive way in which the prevention of malaria is discussed, not only under its proper heading, but again in connection with mosquitoes.

THE NURSING OF INFECTIOUS DISEASES. By F. J. WOOLLACOTT, M.A., M.D., B.Ch.(Oxon.), D.P.H. (London: Faber & Gwyer.)

Has received useful additions in its fourth edition, which make it a valuable text-book for nurses studying for the fever section of the General Nursing Council's examinations. The charts and reference tables are clear and helpful, and the book will be useful to those engaged in private nursing. The price is 4*s*.

THE INVERT. By ANOMALY. With an Introduction by Dr. R. H. THOULESS. (London: Baillière, Tindall & Cox, 1927.) 160 pp.

"The Invert" is an essay on homosexualism written by a homosexualist, for the benefit and guidance of his fellow sufferers and of those who would advise them.

The book is not technical in any sense; it is the philosophic result of the experiences of an otherwise normal man.

It possesses four great qualities, and a fifth which is, in this connection, the most valuable of all. The four are insight, courage, high morality and an exquisite sensitivity. The fifth is common sense.

The quality of sensitivity will not appeal to all readers. Many normal men think that it is itself abnormal, the especial attribute of the invert. So, in a sense, it is; but herein lies its value, for he who would help the invert can only do so through a very profound sympathy, a fellow feeling which postulates an equal or higher degree of sensitivity. Such refinement of feeling can only be achieved by a few normal men, and then only by careful study. The value of the book now becomes partly evident—it is an exercise in tact, and in tact applied through the medium of common sense. The social problem of homosexualism can only be solved by fair and rational treatment. At the best, the solution is palliative; but the results which may fairly be hoped for, judging from this book, are such as to make the life of every invert well worth living.

INSOMNIA. By H. HILL, M.B., B.S., M.R.C.P. (A reprint from the *Journal of the R.N.M.S.*, April, 1927.)

The author in his short treatise on "Insomnia" has attempted to cover a vast field, not only in clinical medicine, but in physiology, comparative anatomy and therapeutics. He divides insomnia into two main groups—primary and secondary. His opening sentence on "primary insomnia" almost refutes his argument for such a classification. The therapeutic measures cover a large part of the Pharmacopœia. He lays stress on the use of hypnotism. The article is of interest but rambling, and would have been of more value if the author had devoted himself to one or two aspects of insomnia alone.

A SYNOPSIS OF SURGERY. (Illustrated.) By ERNEST W. HEY GROVES, M.S., M.D., B.Sc.(Lond.), F.R.C.S.(Eng.). (Bristol: John Wright & Sons, Ltd.) Pp. 650. Price 17*s*. 6*d*. net.

In this, the eighth edition of a synopsis first published in 1908, a complete revision of the text, in the light of modern theory and practice, has been undertaken. Omissions such as anterior poliomyelitis have been remedied, the more recent classification of spinal tumours has been introduced, the chapter on hydrocephalus has been classified and added to, and there are additions to the chapters on enlargements of the thyroid and tumours of the jaw. Intended as a work in which the more salient facts of surgical practice should be set out in such a manner as to be most easily referred to or revised, it has enjoyed a well-deserved popularity. But while, with increasing additions, it makes a wider appeal to the practitioner as a book of reference, its length detracts much from its usefulness as a book of revision. It is, however, essentially clinical in its outlook, and the fact that it has been compiled from notes made in preparing students for examinations should do much to recommend it.

THE OPERATIONS OF SURGERY. ROWLANDS AND TURNER. Tenth edition. Two vols. 900 illustrations. (J. & A. Churchill.) Price £3 10*s*.

These volumes, the descendants of the famous book by Jacobson, maintain the very high reputation of a work that is almost beyond criticism. The book differs from most others on operative surgery in containing a great deal of clinical matter and invaluable practical details. It was this feature that rendered it indispensable to the surgeon and to the graduate working for the final F.R.C.S. At one time a careful study of the work was considered to be adequate preparation for this examination.

A full account is given of all the important operations and their principal variations. This has been brought up-to-date, and while individual surgeons may criticize the omission of some special operation in which they may be interested, this cannot detract from the great value of the book as a whole. The authors are to be congratulated on their revision.

RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

JUST, T. H., M.B., B.Ch., F.R.C.S. "Lateral Sinus Thrombosis without Otorrhœa; Septicæmia: Subsequent Tonsillectomy; Acute Nephritis; Recovery." *Proceedings of the Royal Society of Medicine*, March, 1927.

——— "Right-sided Temporo-sphenoidal Abscess without Localizing Signs." *Proceedings of the Royal Society of Medicine*, May, 1927.

——— "Left Cerebellar Abscess." *Proceedings of the Royal Society of Medicine*, May, 1927.

MAINGOT, RODNEY, F.R.C.S. "Gummatous Colitis: Report of a Case." *Proceedings of the Royal Society of Medicine*, June, 1927.

MYERS, BERNARD, C.M.G., M.D., M.R.C.P. "Case of Essential Thrombo-Cytopenic Purpura Hæmorrhagica a Year after Splenectomy." *Proceedings of the Royal Society of Medicine*, March, 1927.

——— "Pituitary Adiposity." *Proceedings of the Royal Society of Medicine*, April, 1927.

——— "Atresia of the Duodeno-Jejunal Junction." *Proceedings of the Royal Society of Medicine*, June, 1927.

——— "Splenectomy for Essential Thrombocytopenic Purpura Hæmorrhagica." *Proceedings of the Royal Society of Medicine*, June, 1927.

OKELL, C. C., M.C., M.B., B.Ch. (and PARISH, H. J.). "The Standardization of Tuberculin." *British Journal of Experimental Pathology*, June, 1927.

POWER, Sir D'ARCY, K.B.E., F.R.C.S. "The Place of the Tudor Surgeons in English Literature." *Proceedings of the Royal Society of Medicine*, May, 1927.

RIDOUT, C. A. SCOTT, M.S., F.R.C.S. "A Case of Chronic Diffuse Tuberculosis of Nose, Pharynx, Epiglottis and Larynx." *Proceedings of the Royal Society of Medicine*, March, 1927.

——— "Discussion on the Treatment of Chronic Non-tuberculous Infection of the Lungs." *Proceedings of the Royal Society of Medicine*, March, 1927.

ROBERTS, J. E. H., F.R.C.S. "Discussion on the Treatment of Chronic Non-tuberculous Infection of the Lungs." *Proceedings of the Royal Society of Medicine*, March, 1927.

ROBINSON, C. A., B.A., M.B., D.M.R.E. "Discussion on Climacteric Arthritis." *Proceedings of the Royal Society of Medicine*, March, 1927.

ROLLESTON, Sir HUMPHRY, Bart., K.C.B., M.D., F.R.C.P. "Discussion on Light Treatment in Surgical Tuberculosis." *Proceedings of the Royal Society of Medicine*, April, 1927.

——— "The Mackenzie Davidson Lecture on the Effects of Radiations on Patients and Radiologists, and on Protection." *British Medical Journal*, July 2nd, 1927.

ROSE, FRANK, F.R.C.S. "Foreign Body removed from Right Bronchus." *Proceedings of the Royal Society of Medicine*, March, 1927.

ROXBURGH, A. C., M.D. "Case of Permanent Freckles Treated with Pure Carbolic Acid." *Proceedings of the Royal Society of Medicine*, February, 1927.

——— "Demonstration of the Detection of Ringworm Hairs on the Scalp by their Fluorescence under Ultra-violet Light." *Proceedings of the Royal Society of Medicine*, June, 1927.

SAXBY-WILLIS, F. E., M.D. "Acromegaly of (?) Traumatic Origin, with Proliferative Changes in the Interphalangeal Joints of the Left Thumb and Middle Finger." *Proceedings of the Royal Society of Medicine*, March, 1927.

——— (and OGILVIE, W. H., M.Ch.). "Radicular Paresis of the Right Hand Associated with Abnormal Bone Formation of the Seventh Cervical Vertebra and Sprengel's Shoulder." *Proceedings of the Royal Society of Medicine*, March, 1927.

SCOTT, SYDNEY, M.S., F.R.C.S. "Left Temporo-sphenoidal Abscess." *Proceedings of the Royal Society of Medicine*, May, 1927.

——— "Right Cerebellar Abscess." *Proceedings of the Royal Society of Medicine*, May, 1927.

——— "Two Cases of Cerebellar Abscess. Previously reported." *Proceedings of the Royal Society of Medicine*, May, 1927.

——— "Left Temporo-sphenoidal Abscess Opened Sixteen Days after the Onset of Acute Otitis Media; Outstanding Symptom, Auditory Amnesia ('Name-Amnesia')." *Proceedings of the Royal Society of Medicine*, May, 1927.

SHAW, WILFRED, M.A., M.B., B.Ch.(Cantab.). "Some Pathological Forms of the Corpus Luteum." *Journal of Obstetrics and Gynæcology of the British Empire*, Summer number, 1927.

SPENCER, W. G., O.B.E., M.S., F.R.C.S. "Eighteen Letters written by Edward Jenner to Alexander Marcet between the years 1803 to 1814, presented to the Library of the Royal Society of Medicine by Dr. William Pasteur." *Proceedings of the Royal Society of Medicine*, March, 1927.

STONE, G. KENNETH, D.M., M.R.C.P. "Case of Splenomegaly for Diagnosis." *Proceedings of the Royal Society of Medicine*, June, 1927.

STUART-LOW, W., F.R.C.S. "Paracentesis Tympani: A Practitioner's Operation." *Practitioner*, July, 1927.

THURSFIELD, HUGH, D.M., F.R.C.P. "Discussion on the Diagnosis and Treatment of Colitis." *Proceedings of the Royal Society of Medicine*, February, 1927.

——— "Discussion on the Treatment of Chronic Non-tuberculous Infection of the Lungs." *Proceedings of the Royal Society of Medicine*, March, 1927.

WEBER, F. PARKES, M.D., F.R.C.P. "Polycythæmia Hypertonica." *British Medical Journal*, July 16th, 1927.

——— "Discussion on the Diagnosis and Treatment of Colitis." *Proceedings of the Royal Society of Medicine*, February, 1927.

——— "Discussion on the Treatment of Gangrene of the Extremities." *Proceedings of the Royal Society of Medicine*, February, 1927.

——— "Aleukæmic Lymphadenosis." *Proceedings of the Royal Society of Medicine*, March, 1927.

——— "Prurigo of Besnier and Rasch in an Adult." *Proceedings of the Royal Society of Medicine*, March, 1927.

——— "Functional Peculiarity of Gait in a Girl with Endocrine Disorder. (Tendency to Obesity of 'Cerebral Type')." *Proceedings of the Royal Society of Medicine*, April, 1927.

——— "Persistent Erythema, with Ischæmic Circulation, in the Left Foot, possibly in part connected with Prolonged Use of a Plaster Bandage for Tuberculous Disease of the Left Knee." *Proceedings of the Royal Society of Medicine*, April, 1927.

——— "Two Cases of Chilblainy Condition of the Legs somewhat resembling Erythema Induratum; also a Case of Erythema Induratum for Comparison." *Proceedings of the Royal Society of Medicine*, April, 1927.

——— "Discussion on Light Treatment in Surgical Tuberculosis." *Proceedings of the Royal Society of Medicine*, April, 1927.

——— "Erythema Nosodum leading to the Detection of Latent Hilus Tuberculosis." *Proceedings of the Royal Society of Medicine*, May, 1927

——— "Chronic Relapsing Pemphigus or Dermatitis Herpetiformis in an Old Man with Chronic Lymphocytosis." *Proceedings of the Royal Society of Medicine*, May, 1927.

——— "Persistent Erythema with Ischæmic Circulation in the Left Foot, possibly in part connected with Prolonged Use of a Plaster Bandage for Tuberculous Disease of the Left Knee." *Proceedings of the Royal Society of Medicine*, May, 1927.

——— "Facial and Aural Congenital Mal-development in one of Twins." *Proceedings of the Royal Society of Medicine*, June, 1927.

——— "Stenosis (Co-arctation) of the Aortic Isthmus, with Sudden Death from Rupture of a Cerebral Aneurysm." *Proceedings of the Royal Society of Medicine*, June, 1927.

——— (and GUNEWARDINE, T. H., M.R.C.S.). "Lipodystrophia Progressiva with the Face only affected." *Proceedings of the Royal Society of Medicine*, February, 1927.

EXAMINATIONS, ETC.

UNIVERSITY OF CAMBRIDGE.

First Examination for Medical Degrees, Easter Term, 1927.

Part I. Chemistry.—Jones, J. D. M., Warren, C. B. M.

Second Examination for Medical Degrees, Easter Term, 1927.

Part II. Human Anatomy and Physiology.—Flemming, A. A. G., Lockhart, J. M. C.

Third Examination for Medical Degrees, Easter Term, 1927.

Part I. Surgery, Midwifery and Gynæcology.—Alsop, A. F., Barendt, G. H., Beattie, W. J. H. M., Briggs, W. A., Brown, A. C., Bullen, H. B., Burrows, H. J., Cosgrove, E. C., Eason, G. A., Hensman, J. S., James, E. T., Oakley, D. E., Poole, J. C. C., Rose, E. E. F., Salt, P. G., Sinclair, M. R., Watts, C. F., Wilkin, W. J.

Part II. Principles and Practice of Physic, Pathology and Pharmacology.—Burrows, H. J., King, F. H., Mellor, A. W. C., Pearce, R., Slinger, L. A. P., Tanner, G. M., Watts, C. F., Windle, R. W., Woodrow, C. E.

UNIVERSITY OF LONDON.

M.D. Examination.

Branch I. Medicine.—Klionsky, G., Morlock, H. V.

Branch IV. Midwifery and Diseases of Women.—Burt-White, H. (University Medal).

First Examination for Medical Degrees, July, 1927.

Passed.—Barasi, G., Capper, W. M., Cates, B., Corea, F. E., Cuthbert, T. M.,* Davies, W. H. D., Dennys, J. D., Franklin, C. B., Gilbert, R. G., Greenberg, A., Higginson, H. C. H., Hill, J. R., Hosford, M. D. C., Iliff, A. D., Isaac, R. H., Jardine, D. K., Knox, R., Kravchick, W., Morgan, G. R., Pierre, H. H., Race, R. R., Rosenfeld, P., Scowen, E. F., Strong, J. R., Wells, G.

*Awarded a mark of distinction in Inorganic Chemistry.

Second Examination for Medical Degrees, July, 1927.

Part I.—Bamford, H. C., Beard, A. J. W., Cook, A. B., Crabb, D. R., Greenberg, A., Harris, C. H. S., Kirk, G. W., Lloyd, M. A., Macfarlane, R. G., Milsome, J. St.G., Petty, G. F., Ringdahl, K. E. O., Rosenfeld, P., Staunton, H. W. G., Strong, J. R., Vaughan, H. B. D.

Part II.—Barber, A., Burgess, W. J., Coorland, H., Fawcett, R. E. M., Frankenberg, P., George, T. C. R., Grace, A. H., Lannaman, L. J., List, H. M., Malley, M. J., Renbom, E., Robb-Smith, A. H. T., Ross, K. M., Schlaff, M., Tierney, T. F., Watkin, J. H.

ROYAL COLLEGE OF PHYSICIANS.

The following have been admitted Members:
Brooke, E. B., Fletcher, E. T. D., Joule, J. W., Wilson, H. L.

CONJOINT EXAMINING BOARD.

Pre-Medical Examination, July, 1927.

Chemistry.—Bamford, J. B., Brookman, G. H., Brownlees, T. K., Furber, L. B., Jackson, J. M., Lynes, S., Orpwood, R. M. M. C., Oxley, W. M., Savage, O. A., Thomas, J. C. S. Woods, T. R.,

Physics.—Bamford, J. B., Brookman, G. H., Furber, L. B., Hole, E. K., Jackson, J. M., Lynes, S., Orpwood, R. M. M. C., Oxley, W. M., Woods, T. R.

First Examination.

Physics.—MacColl, A. H.
Elementary Biology.—MacColl, A. H.

Second Examination.

Physiology.—Davy, A. F., Jenkinson, E. N., Williams, R. N. H.
Part I. Anatomy.—Jenkinson, E. N.
Part II. Pharmacology and Materia Medica.—Andreasen, A. T., Holden, C. E., Smith, L. J., Van Rossum, G. P. A.

The following have completed the examination for the Diplomas of M.R.C.S., L.R.C.P.:
Attwood, J. H., Bell, A. C. H., Chaudhuri, A. M., Eason, G. A., Edwards, J. A., Erian, A., Ernst, M. R., Goodliffe, R. V., Hancock, P. E. T., Hillaby, H., Hussein, M. K., Jenkins, J. L. G., Langhorne, D. A., Pentreath, E. U. H., Phillips, R. F., Platel, M. W., Roberts, E. H., Rosser, E. ap I., Royle, H., Tracey, H. A., Wilson, W. M.

D.O.M.S.

The Diploma has been conferred on:
Métivier, V. M.

D.P.H.

The Diploma has been conferred on:
Donelan C. J.

D.P.M.

The Diploma has been conferred on:
Coleman, S. M., Slater, G. N. O.

L.M.S.S.A.

The Diploma of the Society has been granted to the following:
Jenkinson, S., Smith, S. B. S.

CHANGES OF ADDRESS.

BURT WHITE, H., 114, Harley Street, W. 1. (Tel. Langham 2157.)
DAVIES, TREVOR G., Surg. Lt., R.N., Haslar Hospital, Portsmouth.
FISON, J., "Stafford House," 59, York Place, Harrogate.
FOOTE, R. R., The Manor House, Maidenhead, Berks.
JORY, N. A., 49, Harley Street, W. 1.
LADELL, E. W. J., Windsor Lodge, Balfour, Capt Province, S. Africa.
LLOYD, W. ERNEST, 140, Harley Street, W. 1. (Tel. Langham 2720.) And 29, Bramham Gardens, S.W. 5. (Tel. Kensington 4103.)
MAITLAND, C. T., 11, Beechcroft Avenue, Golders Green, N.W. 11.
MAPLES, E. E., P.O. Box 33, The Warren, Calabar, Nigeria.
MAXWELL, J. L., 236, Seymour Road, Shanghai, China.
PERRAM, E. A., Over-Storvey, Dawlish Road, Teignmouth, S. Devon.
ROLES, F. C., 25D, Fitzjohn's Avenue, Hampstead, N.W. 3. (After September 12th.)
TANNER, G. M., Newton Abbot, S. Devon.

APPOINTMENTS.

ALEXANDER, G. L., M.B., B.Ch., appointed Medical Officer, Freetown, Sierra Leone.
Miss E. M. BRINTON, who took the International Course at Bedford College, 1925–1926, has been appointed to assist in carrying out an investigation being made in Birmingham by the British Medical Research Council into the relation between diet and dental caries.
DAVIES, C. SIMS, M.R.C.S., L.R.C.P., appointed R.M.O. to the Worcester Hospital.
DAY, C. A., M.R.C.S., L.R.C.P., appointed Resident Surgical Officer to the Wolverhampton and Staffordshire Hospital.
JORY, N. A., F.R.C.S., appointed Surgeon to Ear, Nose and Throat Department, Royal Northern Hospital.
MÉTIVIER, V. M., M.R.C.S., L.R.C.P., appointed Ophthalmic House Surgeon to the Royal Infirmary, Sheffield.

BIRTHS.

FLETCHER.—On August 15th, 1927, at 98, Harley Street, W. 1, to Christina, wife of Herbert Morley Fletcher, M.D., F.R.C.P.—a daughter.
LEDGER.—On July 31st, 1927, at the British Consulate, Sistan, to Cicely (*née* Squire), wife of Capt. L. K. Ledger, I.M.S.—a son.
ROBERTSON.—On July 29th, 1927, to Dr. and Mrs. M. K. Robertson, of 116, Mortlake Road, Kew Gardens, Surrey—a daughter.

MARRIAGE.

BOURNE—COTONIO.—On August 3rd, 1927, at New Orleans, Geoffrey Bourne, M.D., M.R.C.P., elder son of Mr. and Mrs. James Bourne, of Bedford Park, London, to Margherita Cotonio, Ph.D., daughter of Mr. and Mrs. Cotonio, of New Orleans, U.S.A.

DEATHS.

BARNES.—On August 11th, 1927, at the Prince of Wales's Hospital, South Tottenham, Leonard Stewart Barnes, M.R.C.S., L.R.C.P., of Whitwell, Welwyn, aged 58.
ROACHE.—In July, 1927, William Henry Roache, of Rutland House, Heanor Road, Ilkeston, Derbyshire.
SHARPIN.—On August 4th, 1927, at 11, Lansdowne Road, Bedford, Edward Colby Sharpin, eldest son of the late Henry Wilson Sharpin, Esq., of 1, St. Paul's Square, Bedford, aged 68.

ACKNOWLEDGMENTS.

Archives of Medical Hydrology—Annual Report of the Royal Southern Hospital, Liverpool—The British Journal of Nursing—Giornale della Reale Società Italiana d'Igiene—Guy's Hospital Gazette—The Hospital Gazette—The Kenya Medical Journal—The Journal of the Research Defence Society—Lebanon Hospital Report—St. Mary's Hospital Gazette—The Magazine of the Royal Free Hospital—The Medical Journal of Australia—The Medical Review—The Nursing Times—The Post-Graduate Medical Journal—Queen's Medical Magazine—Revue de Médecin—The Stethoscope.—Sydney University Medical Magazine.

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